Is Healthcare Caring in Hawai'i? Preliminary Results from a Health Assessment of Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex People in Four Counties

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Abstract

This paper presents findings from a statewide needs assessment of lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI) people in Hawai'i that relate to health status and health-related risk factors such as having health insurance coverage, having a regular doctor, experiencing sexual orientation (SO) or gender identity/expression (GI/E) discrimination in health/mental health care settings, and delaying care due to concerns about SO and GIE discrimination in Hawai'i, Honolulu, Kaua'i, and Maui counties. Results suggest that LGBTQI people in these counties generally rated their self-assessed health as "very good" or "excellent," but had slightly higher rates of smoking and less health insurance coverage than the general population of Hawai'i. Many respondents reported challenges to their health, and negative experiences with healthcare. Unlike prior studies that have shown no difference or a rural disadvantage in care, compared to urban locations, Hawai'i's counties did not have a clear rural disadvantage. Honolulu and Kaua'i Counties demonstrated better health indicators and lower percentages of people who had delayed care due to gender identity concerns. Findings suggest that health/mental health care providers should address potential bias in the workplace to be able to provide more culturally competent practice to LGBTQI people in Hawai'i.

Individual prejudice, social stigma, and systemic discrimination have historically harmed the health and well-being of people identifying as lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI).[1-4] These marginalizing factors produce barriers to optimal health care and potentiate disparate health outcomes among LGBTQI people. For example, in the Lambda Legal national survey, more than half of LGBTQI respondents (N=4916) experienced some form of discrimination in the healthcare system; such experiences were linked to delayed treatment seeking and associated with disparate cancer outcomes, use of alcohol, tobacco, and other drugs, and other poor health/mental health outcomes.[1,5] The extent of disparities encountered by LGBTQI people is not fully known due to variation among health organizations in collection of information on sexual orientation and gender identity.

Lack of culturally appropriate health and social services that are sensitive to sexual orientation and gender variance deter or delay access to essential healthcare and social services for LGBTQI populations, potentiating disparate health outcomes and uneven access to care.[6-10] Experiences of sexual orientation or gender identity/expression discrimination can be further complicated by having other stigmatized identities. For example, experiences of discrimination are more likely to occur when racial/ethnic minority status is reported with transgender status,[4,5,11] suggesting that racial/ethnic minority LGBTQI people may be at most risk for negative health outcomes. In addition, findings have been mixed in regard to geographic location, with some research suggesting no differences between urban and rural locations while others have found that rural LGBTQI people are at a disadvantage in accessing culturally competent care.[12-14]

The paucity of empirically-derived knowledge has been problematic for developing or maintaining culturally appropriate services in Hawai'i. The limited research available suggests similar health experiences in the continental United States, namely that LGBTQI people in Hawai'i have been found to have high rates of smoking,[11,15] to be at risk of HIV infection,[6,16] and that transgender women have been found to have high rates of substance use and sexual risk-behaviors that put them at risk for sexually transmitted infections.[6,11,16] To extend current national and local efforts on closing the gap in health outcomes and needs, and to identify the unique needs of LGBTQI people in Hawai'i, the researchers analyzed data from a statewide needs assessment among LGBTQI persons and compared health-related variables across four counties. These counties included one county designated by the Census as urban (Honolulu County) and three counties that are designated by the Census as rural (Kaua'i, Maui, and Hawai'i Counties) to determine if there are rural/urban differences in the health and healthcare related experiences of LGBTQI people in Hawai'i.

Methods

Based on collaboration with a variety of LGBTQI-serving groups in the state, and on the perceived need for a broad survey that covers a range of topics rather than one that focused on any one topic, a needs assessment was developed from 2012 to 2013. LGBTQI-serving community groups were instrumental in survey design and implementation, such as by selecting topic areas to be covered, reviewing proposed questions, helping finalize the completed survey instrument, and later recruiting potential participants. After receiving IRB approval from the University of Hawai'i, data was collected as part of a statewide needs assessment of LGBTQI people in Hawai'i that was open from June – August of 2013. In addition to demographic questions, identification of LGBT community needs, and questions related to experiences of discrimination and violence, the needs assessment asked health-related questions. Results from the entire needs assessment can be found online, but this report focuses on health-related variables in the needs assessment.[17] Respondents were asked to rate their overall health among five categories (excellent, very good, good, fair, poor), use of tobacco products, whether or not they have a doctor they see

regularly, health insurance coverage and source, and types of chronic conditions. Experiences of sexual orientation (SO) and gender identity or expression (GI/E) discrimination in health/mental healthcare settings were measured by two questions asked twice, once in regard to sexual orientation and once in regard to GI/E: (1) "Have you ever been refused physical or mental health care because of your sexual orientation (gender identity/expression) in Hawai'i?", (2) "Have you ever been treated poorly while receiving physical or mental health care because of your sexual orientation (gender identity/expression) in Hawai'i?" Two additional questions asked about choosing to delay health care seeking due to concerns about either sexual orientation or GI/E: "In Hawai'i have you ever delayed getting help from social service or health providers due to your sexual orientation (gender identity/expression)."

A variety of recruitment methods were utilized, including (1) snowball sampling by asking key community contacts to refer likely participants, (2) emails sent through a LGBTQI-serving community agency's listserv, (3) attendance at Pride events in Honolulu, Hilo, and Kaua'i, and (4) use of social media websites related to LGBTQI services, functions, or events in Hawai'i. Potential respondents were given the choice of either a paper survey or a card with a link to the online survey at venue-based recruitment sites, and all electronic recruitment through email and social media contained the survey link to the online survey. The three criteria for participation were (1) living in the State of Hawai'i, (2) identifying as a sexual minority or transgender, and (3) being 18 years or older. Based on these multiple recruitment strategies, 731 people took the survey, however, 21 of those respondents did not meet the criteria and were dropped from the analysis (N = 710).

Due to the complexities of both SO and GI/E, items relevant to these domains included multiple choice items and related open-ended questions where respondents could self-select how they describe their SO or GI/E. For example, respondents were asked the sex coded on their birth certificate (male, female, or other) and then asked to indicate in their own words the term they preferred for describing their current gender identity. Participants were also asked how others perceive their gender identity—ranging from "man all of the time" to "female all of the time" while including options for androgynous or blended. People's definitions of their own gender identity varied, but for ease of reporting, identities were collapsed into seven categories: (1) cisgender (biological sex is consistent with GI/E) woman, (2) gender nonconforming woman (eg, "butches," "studs"), (3) transgender woman (including those who identify as *māhūwahine*, *fa'afafine*, etc), (4) transgender man (including *māhūkane*), (5) gender nonconforming man (men who identified as being feminine), (6) cisgender man, and (7) those who identified as androgynous (eg, genderqueer, blended). In regard to SO, when ambiguous terms such as "queer" were cited as primary identity, participants were recoded according to gender (for example, a woman who said she was "gay" was recoded into "lesbian/woman who has sex with women") to avoid confusing gender and SO. People who identified as cisgender and heterosexual with no same-sex attractions were dropped from the study, although some participants remained who identified as straight but responded that they were gender nonconforming/transgender, or that they had same sex attractions. No participants specifically self-identified as "intersex," although a handful of respondents reported having disorders of sexual development, such as androgen insensitivity, and could be classified as intersex individuals by some medical definitions.

Results

The majority of people in the sample identified themselves as men (58.3%), of whom most were cisgender men, gender nonconforming men, and transgender men. Amongst the 40.7% who identified as women, most were cisgender women, followed by gender non-conforming women, and transgender women. One percent identified as androgynous. In regard to SO, the majority identified as gay men or men who have sex with men, followed by women who identified as lesbians or women who have sex with women, then bisexual/pansexual men and women. The age of respondents ranged from 18 to 83, with a mean of 42.8 (SD = 14.8). The percent of respondents (35.2%) who lived in rural counties (Maui, Kaua'i, and Hawai'i) closely matched the percent of people living in rural counties in the state population overall. When asked to identify primary racial/ethnic identity, a greater portion of the sample was White (53.4%) than in the overall population of Hawai'i (26.1%),[14] but otherwise had a diverse set of respondents that reflected the diversity of Hawai'i, including: Native Hawaiian (12.0%), Japanese (6.6%), Mixed Race/Ethnicity (6.3%), Filipino (5%), Latino/Hispanic (4.0%), Mixed Asian Ethnicities (3.3%), Chinese (2.1%), Pacific Islander (1.4%), Black, (1.3%), Vietnamese, Jewish/Semitic, Samoan, and Korean (1% each), and other races/ethnicities (1.1%).

Health Status-related Variables by County

The majority of participants rated their overall health as "excellent" or "very good." There were no statistically significant differences between the counties, suggesting that LGBTQI people across the islands share a similar level of overall health. When asked about specific health issues, 42.3% of respondents reported at least one type of chronic physical or mental health condition. This is similar to other reports about the percent of chronic conditions in the state's general population.[19] Statistically significant differences emerged between the counties ($\chi^2 = 7.87$, $P < .05$), with Honolulu County reporting the lowest percent of chronic conditions and Hawai'i County reporting the highest. Overall, 18.4% of the sample reporting using tobacco products at least occasionally, with 9% who used regularly. No statistically significant differences emerged between the counties in overall tobacco use.

Barriers to Care

The majority of respondents reported that they had health insurance coverage, and that they received those benefits primarily from their employers (54.6%), followed by the government (17.1%). The percentage of reported not having health insur-

ance (11.1%) is almost twice the percent of people reported as uninsured by the annual Hawai'i Health Survey 2010, suggesting that LGBTQI people may have additional challenges to being insured compared to other residents of Hawai'i.[19] When examining percentages of those lacking health insurance across the islands, there was a statistically significant difference ($\chi^2 = 9.01$, $P < .05$), with the highest percent of uninsured people in Maui and Hawai'i Counties, and the lowest percent in Kaua'i County. Overall, 27.4% of the sample reported that they did not have a doctor that they saw on a regular basis. No statistically significant difference between the counties emerged, however, the percentages of participants who reported that they do not have a regular medical provider was higher in each county than the percent among all adults in each county reported in the Hawai'i Behavioral Risk Factor Surveillance System (BRFSS: Kaua'i = 14.4%, Maui = 20.2%, Hawai'i = 19.8%, Honolulu = 13.6%).[20] To explain some of the challenges of finding a regular doctor, one straight *māhūwahine* said that her community's challenges included a lack of "medical access to hormone therapy and the lack of service providers willing to take on the transgender community as patients. HIV specialized doctors are usually the only ones willing to monitor and administer hormone replacement therapy to the transgender community" highlighting the unique challenges for transgender people seeking a doctor for general medical care, as well as transition-related care.

Discrimination in Healthcare and Other Social Services

Statewide 12.5% reported ever having been refused treatment or treated poorly in health care settings due to SO and 8.9% for GI/E. No significant discrimination differences emerged by county, although this may be due in part to the low number of respondents on Kaua'i who reported these experiences, thus resulting in a low cell size. In response to qualitative questions, respondents highlighted how even well-meaning doctors can still cause discomfort in the medical setting. For example, one cisgender gay man wrote:

> "Doctors stereotype me. I recently went to a new doctor for a physical…Despite telling the doctor I am in a 21 year long monogamous relationship with another man, he insisted on checking me for a range of STDs and HIV. He didn't even address any of the concerns for which I went. I felt like the doctor was projecting his own misguided beliefs about gay men onto me…I left without proper medical care for the concerns I had…I doubt that straight couples are subjected to such disrespect of their monogamous relationships of 21 years."

Delaying Care

Percent of respondents who delayed seeking care because of concerns about treatment due to LGBTQI identity were even higher than those who had experienced discrimination in healthcare setting. There was a statistically significant difference in delaying care due to SO across the counties ($\chi^2 = 10.67$, $P < .01$), although this must be interpreted with caution due to low cell counts for Kaua'i. The relationship remains statistically significant even when Kaua'i was dropped from the analysis. The lowest percent of delaying seeking health/mental health care due to SO was reported in Kaua'i County (3%), while Maui County reported the highest percent of people who delayed care (19%). There were no statistically significant differences in delaying care due to GI/E among the counties.

A genderqueer gay woman wrote about the negative impact of heterosexism in medical settings:

> "Heterosexism appears to be the primary lens that most medical providers use to view their patients. It can be extremely embarrassing as a patient subjected to this and uncomfortable to correct a medical professional. For most of my adult life I didn't go to the doctors (especially gynecologist) due to the medical profession's heterosexist bias."

Discussion

These data indicate that while LGBTQI tend to self-rate their health positively overall, culturally competent healthcare access is of significant concern. Access issues that emerge include insurance coverage, having a consistent medical provider, and discrimination within the healthcare system. Consistent with prior findings of disparities between urban and rural LGBTQI people, rural counties tended to show lower percentages of health insurance coverage, higher percentages of chronic conditions, and higher percentages of people who delayed physical or mental health care due to concerns about their sexual orientation. Structural barriers, such as lack of a consistent medical care provider or health insurance, are cause for concern in overall population health. Receipt of insurance does not guarantee an established source of healthcare; however, it remains an important determinant of utilization. Uninsured persons have poorer health outcomes and are less likely to utilize preventive services.[21] As noted, respondents in our assessment lack health insurance at almost twice the percentage rate of persons in Hawai'i overall, consistent with previous studies that indicate LGBTQI people are more likely to be uninsured than their heterosexual counterparts.[22-24] Lack of insurance is associated with limited healthcare access, poor treatment outcomes, and premature mortality,[25-28] particularly for medically vulnerable populations such as those with HIV, mental health issues, or cancer, among others.[25,27,29,30] What is less clear in the data is why Kaua'i County had higher percentages of LGBTQI adults with health insurance compared to other rural counties, while the other two rural counties reported lower insurance coverage than urban Honolulu County.

In addition to challenges in health insurance coverage, this study uncovered the fact that a quarter of respondents report lacking a regular physician. This percentage is considerably higher than the 17.2% of persons who report not having a personal healthcare provider in the state overall.[27] Similar to findings about insurance coverage, the percentage of LGBTQI adults in Kaua'i County having a consistent doctor is comparable to all adults in that county, suggesting less disparity than in other counties, where the percentage of LGBTQI adults lacking a regular doctor was significantly higher than among all adults

in the respective counties.[20] Having a regular source of medical care is one of the most widely used indicators of access to healthcare.[26] Persons without a consistent medical provider are likely to experience less than optimal health outcome and lack longitudinal, comprehensive care.[31] Taken together, the low percent who have a consistent medical care provider and high percent of uninsured suggest that LGBTQI people in Hawai'i face barriers to care that may have significant impacts on their health and well-being, and that these barriers to care are experienced differently across counties.

Barriers unique to LGBTQI populations are SO- and GI/E-motivated discrimination in services, and concerns about accessing care due to fears of how health providers will handle SO or GI/E concerns. Approximately 15% of respondents report poor treatment and/or being denied services due to SO or GI/E. Almost 10% delayed seeking care for the same reasons. This is congruous with the emerging literature on stigma and discrimination as a barrier to health and social services among LGBTQI populations. Researchers have emphasized the perceived difficulty in getting care when wanted,[32] difficulty accessing LGBTQI-affirmative practitioners,[33] and severe GI/E-bias in provision of services to transgender peoples.[8] In this case, no differences in the percent of participants who experienced discrimination in services across counties emerged, although similar to other health indicators presented in this study, fewer LGBTQI adults in Kaua'i reported these experiences compared to respondents in other counties. Similarly, when examining delaying care due to concerns about SO or GI/E, there were no statistically significant findings in regard to GI/E, but the counties differed in percent of participants who delayed care in each county. Again, Kaua'i County reported the lowest percent of people who had delayed seeking care due to SO, while the other rural counties reported the highest percentage of those delaying care. However, the overall percent of people who identified that they delayed seeking care because of issues around their SO and/or GI/E are cause for concern. These findings suggests that there is still room for improvement among Hawai'i's health/mental health providers in developing culturally competent practice that contributes to the health and well-being of LGBTQI people in the state.

Limitations

Methodological limitations of this study must be considered when developing a response to the needs of LGBTQI people in Hawai'i. Our findings are primarily descriptive and do not imply causality; rather, findings point to the imperative for further research on LGBTQI health outcomes and access to care in Hawai'i. The disadvantage of aggregating diverse communities of LGBTQI people is the loss of specificity for each community and the possibility of overrepresentation from one or more of the populations. Future analyses that examine the different populations contained under the broad "LGBTQI" umbrella are being conducted to provide more specific findings in the state, while this study can only provide overarching findings between counties. This study did not utilize a probability sample and thus not likely to be representative of diverse LGBTQI populations dwelling in Hawai'i. In our study, White participants accounted for more than half of the sample and gender nonconforming or transgender participants made up less that 25% of respondents. Further research on the effect of discrimination on LGBTQI health as disaggregated populations in Hawai'i is merited, along with research with improved recruitment methods such as popular opinion leader or respondent-driven sampling methods that have been shown to be effective in recruiting hard-to-reach populations. Due to sampling strategies that utilized snowball sampling started through LGBTQI-serving organizations, we are less likely to have accessed the most marginalized people within these LGBTQI communities and/or those who are less likely to be attached to LGBTQI organizations, thereby running the risk of under-reporting the social determinants of health, illness, and disease.

Conclusions

As the United States advances in development of patient-centered medical homes, health/mental health providers in Hawai'i have a distinct opportunity to provide services that are experienced as caring by all people, regardless of a person's SO and/or GI/E. Rather than having a clean rural vs urban divide in Hawai'i, where rural counties have less access, lower levels of overall health, and more experiences of discrimination, results suggest that Kaua'i County may be a model of healthcare delivery and cultural competence for other counties in Hawai'i. Although urban Honolulu County may be perceived as having the most access and thus the higher probability of being able to find culturally competent providers, Kauai County emerged as the county with the fewest barriers to care, less discrimination, and lower percentages of people delaying care due to concerns about SO and GI/E. These results also highlight the need for a more culturally competent workforce and the need for training in cultural competence with LGBTQI populations, with particular attention paid to Maui and Hawai'i Counties, although all counties have room for improvement. Although further research is needed to better uncover the relationships between these barriers to care and health outcomes, health providers in Hawai'i should critically examine their practices to consider changes that will make their settings more welcoming and inclusive for LGBTQI people, and follow the recommendations of many health organizations, professional associations, and scholars to move toward culturally competent practice with LGBTQI people.[8,34-36] To promote broad systemic change, training should be made available to all healthcare providers, ancillary, and administrative personnel. Providers should examine their biases and even their well-meaning communications that may be perceived by LGBTQI people as insensitive and function to further alienate LGBTQI people.

Conflict of Interest

None of the authors identify a conflict of interest.

Table 1. Sample Demographics by County					
	Rural Counties			Urban County	State of Hawai'i
	Kaua'i n = 45	Maui n = 78	Hawai'i n = 118	Honolulu n = 445	Total N = 710*
Mean Age (SD)	**45.3 (14.4)**	**47.9 (14.2)**	**44.3 (15.1)**	**41.2 (14.8)**	**42.8 (14.8)**
Gender Identity					
Cisgender Woman	13 (28.9%)	17 (21.8%)	28 (23.7%)	132 (29.7%)	27.5%
Gender Nonconforming Woman	4 (8.9%)	6 (7.7%)	11 (9.3%)	43 (9.7%)	9.0%
Trans Woman	2 (4.4%)	6 (7.7%)	2 (1.7%)	20 (4.5%)	4.2%
Trans Man	0 (0.0%)	2 (2.6%)	4 (3.4%)	11 (2.5%)	2.4%
Gender Nonconforming Man	5 (11.1%)	4 (5.1%)	8 (6.8%)	33 (7.4%)	7.3%
Cisgender Man	21 (46.7%)	42 (53.8%)	64 (54.2%)	201 (45.2%)	48.6%
Androgynous	0 (0.0%)	1 (1.3%)	1 (0.8%)	5 (1.1%)	1.0%
Sexual Orientation					
Lesbian/Woman who has Sex with Women	10 (22.2%)	19 (24.4%)	29 (24.6%)	111 (24.9%)	24.2%
Gay/Man who has Sex with Men	25 (55.6%)	40 (51.3%)	68 (57.6%)	205 (46.1%)	40.0%
Bi/Pansexual	7 (15.6%)	14 (17.9%)	14 (11.9%)	86 (19.3%)	17.6%
Asexual	0 (0.0%)	1 (1.3%)	1 (0.8%)	5 (1.1%)	**1.0%**
Straight	2 (4.4%)	3 (3.8%)	4 (3.4%)	21 (4.7%)	**4.2%**
Other	1 (2.2%)	1 (1.3%)	2 (1.7%)	17 (3.87%)	**3.0%**
Primary Race/Ethnicity					
White/Caucasian	28 (62.2%)	49 (63.6%)	70 (59.8%)	217 (49.3%)	53.4%
Native Hawaiian	6 (13.3%)	7 (9.1%)	16 (13.7%)	55 (12.5%)	12.0%
Japanese	1 (2.2%)	3 (3.9%)	4 (3.4%)	37 (8.4%)	6.9%
Mixed	1 (2.2%)	5 (6.5%)	3 (2.6%)	29 (6.6%)	6.3%
Filipino	4 (8.9%)	3 (3.9%)	4 (3.4%)	23 (5.2%)	5.0%
Latino/Hispanic	4 (8.9%)	2 (2.6%)	3 (2.6%)	19 (4.3%)	4.0%
Other	2 (4.5%)	13 (16.9%)	20 (17.1%)	89 (20.3%)	12.0%

* Counts from individual counties do not add to 710 because some respondents chose not to report their county.

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Table 2. Overall Self-reported Health Concerns by County						
	Rural Counties			Urban County	State of Hawai'i	*P-value*
	Kaua'i n = 45	Maui n = 78	Hawai'i n = 118	Honolulu n = 445	Total N = 710*	
Self-Assessed Health						
Excellent	10 (23%)	16 (21%)	24 (21%)	81 (19%)	19.5%	
Very Good	9 (21%)	33 (42%)	45 (40%)	189 (43%)	41.4%	
Good	19 (44%)	23 (30%)	34 (30%)	133 (30%)	30.8%	
Fair/Poor	5 (11%)	6 (8%)	11 (10%)	36 (8%)	8.3%	
Health Insurance						< .05
No	3 (7%)	13 (17%)	19 (17%)	39 (9%)	11.1%	
Yes, from partner	2 (5%)	6 (8%)	8 (7%)	23 (5%)	5.7%	
Yes, from government	12 (27%)	13 (17%)	23 (20%)	72 (17%)	17.7%	
Yes, from employer	24 (55%)	40 (51%)	56 (49%)	247 (57%)	54.6%	
Yes, other source	3 (7%)	6 (8%)	8 (7%)	56 (13%)	10.9%	
Have a Regular Doctor	17 (85%)	55 (75%)	76 (69%)	282 (72%)	72.6%	
Chronic Condition(s)**	20 (47%)	36 (49%)	57 (52%)	166 (39%)	42.3%	< .05
Uses Tobacco Products	4 (17%)	15 (20%)	24 (22%)	70 (17%)	18.4%	
Experienced Health Care Discrimination						
Sexual Orientation	3 (7%)	12 (17%)	17 (15%)	48 (12%)	12.5%	
Gender Identity or Expression	3 (8%)	10 (14%)	10 (9%)	33 (8%)	8.9%	
Delayed Care						
Sexual Orientation	1 (3%)	13 (19%)	11 (11%)	31 (8%)	8.5%	< .01
Gender Identity or Expression	3 (9%)	9 (14%)	9 (9%)	26 (7%)	7.1%	

*Counts from individual counties do not add to 710 because some respondents chose not to report their county.

**"Chronic conditions" was a yes/no variable based on participants reporting that they had HIV/AIDS, cancer, diabetes, a physical disability, a heart condition, STIs (such as herpes), arthritis, COPD/asthma, a chronic mental health condition, and "other". Participants who reported "other" reported digestive issues, chronic pain, high blood pressure, gonadal issues related to disorders of sexual development or hormone regulation/production issues, and high cholesterol.

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